STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
OFFICE OF FAIR HEARINGS

FILED
Mar 14, 2024, 10:58 am
OFFICE OF FAIR HEARINGS

[redacted],

PETITIONER, **AHCA Case No.: 23-FH3148**

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION,

RESPONDENT.
_____/

FINAL ORDER

Pursuant to notice, the undersigned Hearing Officer convened a telephonic Fair Hearing on the instant case on February 14, 2024, at 9:08 a.m. EST.

APPEARANCES

For the Petitioner: [redacted]
Petitioner's Authorized Representative

For the Respondent: Marielisa Amador
Medical Health Care Program Analyst
Agency for Health Care Administration

STATEMENT OF ISSUE

The issue is whether Respondent proved by a preponderance of the evidence that Respondent's decision to terminate Petitioner's behavior analysis ("BA") services was correct.

PRELIMINARY STATEMENT

All parties and witnesses appeared telephonically. Petitioner's Authorized Representative and [redacted], [redacted] ("[redacted]"), appeared on behalf of the Petitioner. [redacted], Registered Behavior Technician ("RBT") for the Petitioner appeared on behalf of the Petitioner.

Marielisa Amador, Medical Health Care Program Analyst for the Agency for Health Care Administration ("Agency" or "AHCA"), appeared on behalf of Respondent. Dr. David Bicard ("Dr. Bicard"), Board Certified Behavior Analyst at the Doctoral Level ("BCBA-D") and Director of Clinical Operations for eQHealth Solutions, Inc. ("eQHealth"), attended as a witness for Respondent.

Hector, #392554 appeared as the Spanish translator.

Prior to the hearing, Petitioner sent to the Office of Fair Hearings and Respondent a one hundred and twenty-six (126)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "23-FH3148 Faxed DAR and Evidence.pdf." Absent an objection from the Respondent, the undersigned admitted the evidence packet into evidence as Petitioner's Composite Exhibit 1.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a three hundred and nineteen (319)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "[redacted] FH 02.14.2024 1-84.pdf," "[redacted] FH 02.14.2024 85-134.pdf," "[redacted] FH 02.14.2024 135-181.pdf," "[redacted] FH 02.14.2024 182-250.pdf," "[redacted] FH 02.14.2024 251-281 .pdf," "[redacted] FH 02.14.2024 282-308.pdf," and "[redacted] FH 02.14.2024 309-319.pdf." Absent an objection from the Petitioner, the undersigned admitted the evidence packet into evidence as Respondent's Composite Exhibit 1.

Prior to the hearing, Respondent sent to the Office of Fair Hearings and Petitioner a fifty (50)-page evidence packet. The packet appears in the Office of Fair Hearings' case management system as "23-FH3148 AHCA Evidence (Pages 1-50 of 50).pdf." Absent an objection from the Petitioner, the undersigned admitted the evidence packet into evidence as Respondent's Composite Exhibit 2.

FINDINGS OF FACT

1. Petitioner receives Medicaid services on a fee-for-service basis from the Agency. eQHealth is a Quality Improvement Organization contracted by the Agency to review prior authorization requests for services. *See* Respondent's Composite Exhibit 2 at page 2.

2. Petitioner is [redacted]. *See* Respondent's Composite Exhibit 1 at page 22. The Petitioner is diagnosed with [redacted]. Dr. Bicard testified that Petitioner has participated in ABA services with the current provider, [redacted]., for [redacted] years. Dr. Bicard testified that the Petitioner has shown no progress in maladaptive behaviors and minimal progress in skill acquisition and continues to work on some skills with no problem but fails to move on to the next level.

3. As provided in Petitioner's Behavior Analysis Services Plan ("treatment plan" or "behavior plan"), Petitioner is engaging in the following maladaptive behaviors: [redacted]; [redacted]; [redacted]; [redacted]); [redacted]; [redacted]; [redacted]; [redacted]; [redacted]; [redacted]; and [redacted]. *Id.* at 263 - 273. The graphs of the maladaptive behaviors, for the period of May 20, 2023, through November 18, 2023, show the following: for [redacted], Petitioner's incidents remained at approximately [redacted] for

[redacted], Petitioner's incidents remained at approximately [redacted] for [redacted], Petitioner's incidents were between [redacted] for [redacted], Petitioner's incidents remained at approximately [redacted] for [redacted], Petitioner's incidents remained at approximately [redacted]; for [redacted], reduced from approximately [redacted] incidents to approximately [redacted] for [redacted], Petitioner reduced [redacted] incidents from approximately [redacted] to approximately [redacted] and for [redacted], Petitioner's incidents remained at approximately [redacted] *Id.* at 263 – 270.

4. Petitioner requested the continuation of the following BA services: 2,652 units of code 97153, 208 units of code 97155, and 208 units of code 97156 for the certification period of December 3, 2023, through May 29, 2024. *Id*. at 28.

5. On December 5, 2023, Respondent issued a Notice of Outcome ("NOO"), terminating Petitioner's BA services. *Id.* at 28-30. The NOO explained the basis for the termination as follows:

> [T]he requested services are not medically necessary under the following standard(s):
>
> Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.
> Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.
> . . .

The NOO further provided:

> Requested services are denied because documentation is neither showing [i]mprovement nor support for maintenance.
>
> PR Clinical Rationale – Denial: The provider submitted documents including data in graphs that are not consistent with data that are typically reported in behavior analytic treatment. Many of the graphs for maladaptive behavior and skill acquisition show the same general pattern, level, and trend in the data. These data do not appear to have been accurately reported or observed and measured according to standards of care within the field of behavior analysis. According to

> the Florida Medicaid State Plan (page 8, 6.2.3), the data provided must show evidence that the frequency of the maladaptive behavior(s) has decreased since the last review and, if not, that there is a modification of the behavior plan. The recommendations for procedural modifications include: additions/changes to treatment plan to impact behaviors targeted for reduction. Procedural modification should include one or more of the following: antecedent manipulation modifications, modifications of prompting procedures used in acquisition, modifications in consequence-based strategies—ones that either reduce maladaptive behavior or reinforce replacement behavior (e.g., manipulation of reinforcement schedules, switch to a different decelerative procedure), or if lack of progress was due to therapist error (e.g., poor data collection or poor training on intervention methods), how you will address human error. The provider has not addressed the lack of progress during the last observation period and did not amend the treatment plan in relation to the lack of progress or the proposed changes have little chance at improving behavior. The information submitted does not meet standards of care within the field of behavior analysis. This request tis denied.

Id. at 28-29.

6. Petitioner requested reconsideration of the Respondent's decision. On December 16, 2023, Respondent issued a Notice of Reconsideration Determination ("NRD") upholding its decision. *Id.* at 40-41. The NRD states, in pertinent part as follows:

> Specifically the services must be:
>
> Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the patient's needs.
> Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational.
> . . .
> PR Recon Determination: At reconsideration all documents were carefully reviewed. According to the Florida Medicaid State Plan (page 8, 6.2.3), the data provided must show evidence that the frequency of the maladaptive behavior(s) has decreased since the last review and, if not, that there is a modification of the behavior plan. The recommendations for procedural modifications include: additions/changes to treatment plan to impact behaviors targeted for reduction. Procedural modifications should include one or more of the following: antecedent manipulation modifications, modifications of prompting procedures used in acquisition, modifications in consequence-based strategies – ones that either reduce maladaptive behavior or reinforce replacement behavior (e.g., manipulation or reinforcement schedules, switch to a different decelerative

> procedure), or if lack or progress was due to therapist error (e.g., poor data collection or poor training on intervention methods), how you will address human error. The provider has not addressed the lack of progress during the last observation period and did not amend the treatment plan in relation to the lack of progress or the proposed changes have little chance at improving behavior. The information submitted does not meet standards of care within the field of behavior analysis. This denial is upheld.

Id. at 40-41.

7. Dr. Bicard established that eQHealth reviews behavior analysis cases to ensure that providers are giving quality care consistent with the standards enumerated in the BA Policy as well as professional medical standards of applied behavior analysis ("ABA"). eQHealth reviewed the Treatment Plan submitted in this case to determine whether all five (5) conditions of medical necessity are met. Dr. Bicard asserted that Petitioner's services were terminated because the treatment plan is not consistent with generally accepted professional medical standards as determined by the Medicaid program. Further, the Treatment Plan was not individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment.

8. Dr. Bicard asserted that the Treatment Plan submitted by the provider is not implementing the ABA services in a generally acceptable standard of care. Dr. Bicard found a lack of improvement in certain skills and other skills the recipient performs with no problem. Dr. Bicard asserted that ABA services are not intended to be lifetime services, but that the recipient's caregiver should be able to manage the reduction in maladaptive behaviors and the skill acquisition after successful ABA treatment.

9. Dr. Bicard established that an effective treatment plan is built around maladaptive behaviors (which decrease in frequency) and skills to be acquired (which increase in frequency) over the course of treatment. The effectiveness of a treatment plan is determined by reference

to data, which is visually depicted in graphs showing a recipient's progress through treatment. Further, standards of care in ABA require an intervention or modification of the treatment plan if there is no progress after 3-6 weeks of treatment. An intervention is shown by a vertical line on the data graph marking its start point so that progress can be evaluated.

10. Referring to the data graphs in Petitioner's most recently submitted Treatment Plan, Dr. Bicard began with the maladaptive behaviors. The first graph is for [redacted]. This behavior does not meet medical necessity criteria. As explained by Dr. Bicard, this behavior does not interfere with the activities of daily living. Further, the behavior occurs at such a low level it is not meaningful to measure the behavior. The data graph shows that the behavior only occurs [redacted] a week. *Id.* at 263. The next graph is for [redacted]. Dr. Bicard pointed out that this behavior occurs about one time per day in a five hour per day session. This behavior is occurring at a very low level and does not interfere with activities of daily living. Behavior at this low level is not meaningful to record. *Id.* at 264. The providers next graph is for [redacted]. Again, as with the previous graphs, this behavior is occurring at very low levels and is below medical necessity. *Id.* at 265. The next graph is for [redacted]. This behavior occurs about once in a five-hour session and is below medical necessity criteria. *Id.* at 266. The next graph shows [redacted]. This is an easy behavior to treat with ABA. There are two reasons for [redacted]. The first reason is the [redacted] and the second is [redacted]. In this case, the provider failed to address either reason. This graph shows no reduction in behavior. *Id.* at 267. With regard to the data graphs for [redacted], [redacted], and [redacted], Dr. Bicard pointed out that the data graphs show low level occurrences and these behaviors do not affect activities of daily living. *Id.* at 268-270.

11. Dr. Bicard reviewed the replacement skills identified in the Treatment Plan. As Dr. Bicard previously testified, this Recipient performs many replacement skills satisfactorily. Other skills are not improving as necessary. The first skill graph is for [redacted]. The recipient meets this skill requirement about [redacted] of the time. The graph shows no improvement and intervention during the authorization period. This does not meet the standard of care in the ABA field. *Id.* at 277. The next graph is for [redacted]. This skill occurs at a very low level and there has been no improvement during the authorization period. *Id.* at 278. The graph for [redacted] is the next provider graph. The graph shows that the recipient will [redacted] about [redacted] of the time. This graph shows no improvement and no intervention. *Id.* at 279. The next graph is for [redacted] and [redacted]. This behavior does not meet medical necessity and could be taught in an educational setting. *Id.* at 281. The next skill graph is for [redacted]. This graph shows no improvement and no interventions. *Id.* at 282. Dr. Bicard opined that this recipient was not receiving any real ABA type services and the services are below the standard of care.

12. [redacted] testified on behalf of the Petitioner. [redacted] identified [redacted] as the RBT. [redacted] testified that [redacted] had been the RBT since [redacted]. [redacted] stated that the Petitioner had been dealing with [redacted] illness, the [redacted]. [redacted] testified that [redacted] had seen some improvement in the Petitioner's conduct. [redacted] noticed an increase in [redacted] and a [redacted] by the Petitioner when [redacted].

13. [redacted] testified that [redacted] needed the behavior analysis services. [redacted] had seen a change in [redacted] behavior. Recently the family had changed homes. [redacted] now rides the bus to school, however [redacted] does not like the bus. The family does not have a car for transportation. [redacted] is [redacted]

14. On cross-examination of [redacted] and during rebuttal testimony, Dr. Bicard challenged the provider's supervision of the RBT. [redacted] testified that [redacted] supervisor met with [redacted] twice a month on a Saturday for approximately two hours during each meeting. Dr. Bicard stated that the supervision of the RBT was below the standard required by the ABA.

CONCLUSIONS OF LAW

15. The Agency's Office of Fair Hearings has jurisdiction over the subject matter of this proceeding and the parties pursuant to section 409.285(2), Florida Statutes (2019). This order is the final administrative decision of AHCA under section 409.285(2)(a).

16. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 59G-1.100(17)(b).

17. Because Respondent terminated a previously approved service, Fla. Admin. Code R. 59-1.100(17)(g) assigns the burden of proof to the Respondent. The standard of proof in an administrative hearing is a preponderance of the evidence. The preponderance of the evidence standard requires proof by "the greater weight of the evidence" (Black's Law Dictionary at 1201, 7th Ed.).

18. States must provide Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") services to Medicaid-eligible children under age 21 when requested under the Medicaid state plan. *See* 42 U.S.C. § 1396a(a)(43); 42 U.S.C. § 1396d(a)(4).

19. According to 42 U.S.C. § 1396d(r)(5), EPSDT services mean, in relevant part, the following items and services:

> Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illness and conditions discovered by the screen services, whether or not such services are covered under the state plan.

20. A state may place medical necessity limitations on EPSDT services. *See* 42 C.F.R. §§ 440.230(a), (b), (d).

21. Section 409.905(2), Florida Statutes, limits EPSDT services with a medical necessity standard:

> The [Agency] shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems and conditions, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

22. The Florida Medicaid Definitions Policy, incorporated by reference in Fla. Admin. Code R. 59G-1.010, defines "Medically Necessary" or "Medical Necessity" as follows:

> The medical or allied care, goods, or services furnished or ordered must meet the following conditions:
>
> - Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate pain
> - Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs

- Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

Respondent's Composite Exhibit 2 at page 23

23. The BA Policy, incorporated by reference in Fla. Admin. Code. R. 59G-4.125, governs BA services available under Florida Medicaid. The BA Policy provides as follows:

1.0 Introduction
Behavior analysis (BA) services are highly structured interventions, strategies, and approaches provided to decrease maladaptive behaviors and increase or reinforce appropriate behaviors.
. . .
4.0 Coverage Information
4.1 General Criteria
Florida Medicaid covers services that meet all of the following:
- Are determined medically necessary
- Do no duplicate another
- Meet the criteria as specified in this policy

Respondent's Composite Exhibit 2 at page 40, 42.

24. Appendix 9.0 of the BA Policy provides Review Criteria for Behavior Analysis Services. These Review Criteria state as follows:

Review Criteria for Behavior Analysis Services
Behavior analysis (BA) services are considered as either the treatment of choice or as an adjunct treatment modality for a variety of conditions and disorders where maladaptive behaviors are part of the recipient's clinical presentation, including behavioral manifestations of diagnoses such as Autism Spectrum Disorder and other behavioral health conditions.

Critical Elements Necessary for ANY Type of Behavior Analysis Service:
The following critical elements **MUST** be satisfied to qualify for BA services:

a. Eligibility – The recipient must meet all criteria for BA services as outlined in the Behavior Analysis Services Coverage Policy, Rule 59G-4.125, F.A.C.
b. Medical necessity – The recipient must meet medical necessity criteria as outlined in Rule 59G-1.010, F.A.C.
c. The recipient currently engages in maladaptive behaviors
d. These maladaptive behaviors interfere with the recipient's daily functioning

. . .

2. Criteria for Behavior Analysis Services and Reassessments – ALL of the following **MUST** be satisfied:

a. **ALL** critical elements are met
b. An assessment or, if applicable, a reassessment, authored by a lead analyst, is provided. An assessment of the maladaptive behavior(s) is a necessary element of the process of identifying the frequency and magnitude of the behaviors as well as the variables associated with the occurrence of the maladaptive behavior(s). This helps in defining what are the functional consequences of the problem behavior(s) so than an adequate behavior plan can be implemented. This (re)assessment **MUST** include, at a minimum, **ALL** of the following:
c. A behavior plan authored or updated by a lead analyst. The behavior plan is the cornerstone of the delivery of behavior analysis services and it is based on the information obtained in the assessment. It proposes specific interventions to reduce or eliminate the maladaptive behavior. These interventions take into consideration the variables, both present before the behavior, as well as after the behavior, that influence the occurrence of the maladaptive behavior(s). This plan also includes replacement appropriate behaviors for the recipient to engage in instead of the maladaptive behaviors in order to obtain the same function. The plan must be detailed enough to warrant the requested services and include mechanisms to monitor its effectiveness. This **MUST** include, at a minimum, **ALL** of the following:
    i. Observable and measurable descriptions of the maladaptive behavior(s)
    ii. Identified function of the maladaptive behavior(s) behavior as a result of the assessment or reassessment conducted
    iii. Goals and strategies for changing the maladaptive behavior(s)
    iv. Written detailed description of when, where, and how often these goals will be addressed and proposed strategies will be implemented

v. System for monitoring and evaluating the effectiveness of the plan
vi. Safety and crisis plan, if applicable
vii. Summary and recommendations
viii. Discharge criteria
ix. Transition plan (if applicable)

NOTE: Although the assessment and behavior plan were addressed separately in section 2, both of them can be submitted as a single document.

3. Criteria for Continuation of Treatment at the Present Level and/or Using Current Methods: Providers must ensure that ALL of the following criteria are met to request continuation of treatment at the present level or using the current methods. If criteria for 3a is met, but criteria for 3b and/or 3c are not met, then a reduction of the treatment level and/or change of treatment methods may be warranted.

a. ALL criteria listed in 2a, 2b, and 2c regarding critical elements, assessment or reassessment, and behavior plan, are met.
b. The data provided must show evidence that the frequency of the maladaptive behavior(s) has decreased since the last review and, if not, that there is a modification of the behavior plan.
c. The level of functional impairment justifies continuation of BA services. The reviewer utilizes the information provided below as a guide as it relates to the level of functional impairment as expressed through the following behaviors:
    i. Safety - aggression, self-injury, property destruction, elopement
    ii. Communication - problems with expressive/receptive language, poor understanding or use of non-verbal communications, stereotyped, repetitive language Self-stimulating, abnormal, inflexible, or intense preoccupations Self-care - difficulty recognizing risks or danger, grooming, eating, or toileting
    iii. Other- behaviors not identified above

. . .

5. Criteria for Discharge from Behavior Analysis Services - ONE or **MORE** of the following **MUST**
be satisfied:

a. The <u>critical elements</u> are **no longer met.**
b. The data provided shows that the frequency and severity of maladaptive behavior(s) has declined to the point that they no longer pose a barrier to the child's ability to function in his/her environment.

c. The data provided shows the recipient has made no progress toward any goals in the last 12 consecutive months.
d. The level of functional impairment as expressed through behaviors no longer justifies continued BA services.
e. Parent/guardian withdraws consent for treatment.

Respondent's Composite Exhibit 2 at pages 45-47.

25. The Florida Medicaid Authorization Requirements Policy ("Authorization Requirements Policy") (June 2016), incorporated by reference in Fla. Admin. Code R. 59G-1.053, provides general requirements for providers to obtain authorization to render Florida Medicaid services. The Authorization Requirements Policy states, in pertinent part:

> **3.0 Determination Process**
> **3.1 Review Criteria**
> The QIO may use a national standardized set of criteria, or other set of criteria, approved by AHCA, as a guide for authorizations performed at the first review level. If services cannot be approved at the first level review, the QIO's physician peer reviewer will determine medical necessity using his or her clinical judgment, acceptable standards of care, state and federal laws, and AHCA's medical necessity definition.
>
> **3.2 Review Process**
> The QIO will review each authorization request and will approve, deny, or request additional information. The QIO may deny a portion of the requested units of service if it cannot substantiate medical necessity based upon the information submitted.
>
> **3.2.1 Continued Authorization Requests**
> The QIO shall not deny or reduce the amount, frequency, or duration of a service that is already being provided, unless:
> - The reduction is to correct for factual errors or omissions in prior certifications.
> - There is a documented improvement in the recipient's medical condition.
> - There is a documented change in the recipient's circumstances.
> - The reviewing physician determines the recipient will not gain any additional benefit by continuing services at the current level.

Respondent's Composite Exhibit 2 at pages 32-34.

26. In this case, Respondent terminated Petitioner's BA services. *See* ¶ 5 – 6. The NOO and NRD explained that Petitioner's request for continuation of services did not meet medical

necessity as the treatment plan was not "[c]onsistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational." *See* supra ¶ 4-5.

27. As provided in the BA policy (Appendix 9.0, section (a)), and the EPSDT requirements, the recipient must meet the meet the medical necessity criteria as outlined in Fla. Admin. Code R. 59G-1.010. A component of medical necessity is that services must be "consistent with generally accepted professional medical standards." As outlined above, Dr. Bicard provided credible and persuasive testimony identifying several instances where the revised Treatment Plan did not follow generally accepted standards of BA. For example, the Treatment Plan does not show evidence that the frequency of Petitioner's maladaptive behaviors meets the medical necessity criteria. *S*ee ¶¶ 3, 10. Several of the behaviors only occur once a day. *See* ¶ 10. Further, the skill acquisition does not show improvement and does not show that there was a modification or intervention to address the Petitioner's lack of progress. *See* supra ¶ 10-11. Thus, Respondent demonstrated that, based on the information in the record, the requested BA services are not "consistent with generally accepted professional medical standards." Because the services are not consistent with generally accepted professional medical standards, the critical element of medical necessity is not met and, as Dr. Bicard testified, the recipient is not receiving quality ABA services. *See* supra ¶ 11.

28. In this case, Petitioner's provider recommended the continuation of BA services. However, the fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service. *See* supra ¶ 21.

29. Accordingly, Respondent met their burden of proof to show that the requested BA services are no longer medically necessary. Looking at all the evidence relevant to the particular needs of Petitioner, the BA services at issue are not necessary to correct or ameliorate a defect or a physical and mental illness or condition.

30. Upon consideration of the testimony provided, Petitioner's Composite Exhibit 1, Respondent's Composite Exhibit 1, Respondent's Composite Exhibit 2, and the applicable law and policies, the undersigned finds that Respondent proved by a preponderance of the evidence that Respondent's termination of BA services was correct.

DECISION

Respondent's termination of Behavior Analysis services is **AFFIRMED**. Petitioner's appeal based on Respondent's termination of Behavior Analysis services is **DENIED**.

DONE and **ORDERED** this 14th day of March 2024, in Tallahassee, Leon County, Florida.

George L. Winslow, Jr.
23-FH3148
2024.03.14 07:35:17
-04'00'

GEORGE WINSLOW, Hearing Officer
Agency for Health Care Administration
Office of Fair Hearings
2727 Mahan Drive, Mail Stop # 11
Tallahassee, FL 32308-5407

NOTICE OF A RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW, WHICH SHALL BE INSTITUTED BY FILING THE ORIGINAL NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A COPY, ALONG WITH THE FILING FEE PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN

ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE RENDITION OF THE ORDER TO BE REVIEWED.

Copies Furnished To:

[redacted]

AHCA Medicaid Hearing Unit
MedicaidHearingUnit@ahca.myflorida.com